STATEMENT OF
ADRIAN M. ATIZADO
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 15, 2007

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear today at the request of the Subcommittee to offer testimony on behalf of the Disabled American Veterans (DAV) regarding the transition between the Department of Veterans Affairs (VA) and the Department of Defense (DoD) of patients suffering from traumatic brain injury (TBI) and Polytrauma Center Care.

Mr. Chairman, it has been said that TBI is the signature injury of the Iraq war. Blast injuries that shake or compress the brain within the closed skull often cause devastating and permanent damage to brain tissue. Recently I had the opportunity to view a VA-produced DVD about the impact of TBI on a young veteran who served in Iraq. The film is a poignant illustration of the extreme physical and emotional challenges faced by one brain-injured veteran and his family. Like many other severely disabled veterans, that veteran will need a lifetime of care for his injuries. In our opinion, his ongoing rehabilitation and personal struggle to recover is the best justification imaginable for continuation of a strong and viable VA healthcare system. We urge Congress to remain vigilant to ensure that VA programs are sufficiently funded and are *adapted* to meet the unique needs of Operations Iraqi and Enduring Freedom (OIF/OEF) combat service personnel and veterans, while concurrently addressing the needs of older veterans with severe physical disabilities as well as PTSD and other combat-related mental health challenges.

Traumatic Brain Injury

Veterans with severe TBI and polytrauma will require extensive rehabilitation and life-long personal and clinical support, including neurological, medical and psychiatric services, and physical, psycho-social, occupational, and vocational therapies. In an attempt to raise awareness of TBI issues, VA requires mandatory training of all healthcare professionals via a web-based independent study course. However, VA has not yet begun screening all its patients for TBI who are veterans of the Global War on Terror. We note the Secretary's press announcement of February 27, 2007, indicates VA has launched a new nationwide TBI initiative which includes a TBI course that is mandatory for all healthcare professionals, establishing a panel of outside experts to review VA's complete polytrauma system of care, including its TBI program, and beginning this spring VA will initiate a program at all 155 VA medical centers to screen all patients who served in the combat theaters of Iraq or Afghanistan

for TBI. VA also announced on March 6 that it plans to hire 100 new patient advocates to help severely injured veterans and their families navigate VA's systems for healthcare and financial benefits. The veterans service organization (VSO) community has not been briefed on what changes VA has made in its approach to this problem, but we are encouraged that the Secretary seems to be cognizant that the *Independent Budget* VSOs (IBVSOs) made a series of recommendations on this topic in our most recent *Independent Budget* document, and that he is acting early to get VA moving ahead.

The VA's Office of the Inspector General (OIG) issued a revealing report in July 2006, titled: "Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation." The report assessed healthcare and other services provided for VA patients with moderate-to-severe TBI and then examined their status approximately one year following discharge from inpatient rehabilitation. The OIG found that improvement and better coordination of care were needed so veterans could make a smoother transition between DoD and VA healthcare services. The report called for additional assistance to immediate family members of brain-injured veterans, including improved case management and additional caregiver support services.

The importance of caregiver support and assistance is noted in the July 2006 OIG report which states, "Unlike with other types of injury, brain injury often causes emotional difficulties and behavioral problems which can be long lasting. These problems exact a huge toll on patients, family members, and healthcare providers." Family care is clearly a critically important factor in patient recovery and ability to live at home, and that the lack of family support contributes to low functioning of TBI patients. With more severe injuries, the extreme family burden can lead to family disintegration and loss of this major resource of continuing care for veterans. Without question there are many challenges we face in ensuring these veterans and their families get the specialized care and support services they need.

Congress passed a caregiver assistance pilot program in section 214 of Public Law 109-461, but it is likely that VA is only in the early implementation phase of this program. It is a small program, limited to $5 million per year over a two-year period, but the potential in-home assistance provided through that program could be of great help to relieve many families caring for severely injured veterans from Iraq and Afghanistan. In light of the current situation wherein VA is authorized to provide family and caregiver support in very limited situations, we hope the Subcommittee will urge VA to quickly move forward on this pilot program and that Congress will provide oversight and properly assess and adjust or extend the program as needed. A focus group, which includes family caregivers, should be established to evaluate the effectiveness of the pilot program, and to gather input regarding gaps in services and how the program can better meet the needs of these veterans' families and direct caregivers.

We are pleased that VA has designated TBI as one of its special emphasis programs and is committed to working with DoD to provide comprehensive acute and long-term rehabilitative care for veterans with brain injuries. VA reports that it is tailoring its programs to meet the unique needs of severely injured OEF/OIF veterans by assigning case managers to each TBI and polytrauma patient and putting a greater emphasis on understanding the problems of families during the initial care and long-term rehabilitation of these patients. VA

also plans to utilize video conferencing that will allow top specialists to take an active role in the treatment of patients living in remote areas. However, we remain concerned about the level of support families and caregivers of these seriously brain-injured veterans receive as well as the case load of clinical and social work case managers, particularly when effective case management ensures quality medical care and efficient use of healthcare resources.

Mild Traumatic Brain Injury

Military service personnel who sustain catastrophic physical injuries and suffer severe TBI are easily recognized. However, VA experts note that TBI can also be caused without any apparent physical injuries when a veteran is in the vicinity of improvised explosive device (IED) detonation where explosives jar the brain. Veterans suffering a milder form of TBI may not be detected immediately but symptoms can range from headaches to irritability and from sleep disorders to memory problems and depression. It is believed that many OEF/OIF soldiers and marines have suffered mild brain injuries or concussions that have gone undiagnosed, and that symptoms may only be detected when these veterans return home.

Our concern about emerging literature that strongly suggests that even "mild" TBI patients may have long-term mental and other health consequences is heightened by problems identified in the aforementioned OIG report. According to VA's mental health experts mild TBI can produce behavioral manifestations that mimic PTSD or other mental health symptoms and the veteran's denial of problems that can accompany damage to certain areas of the brain, often leads to difficulties receiving services. The DoD has revealed that it still lacks a system-wide approach for identification, management, and surveillance of individuals who sustain mild-to-moderate TBI, in particular those with the mild version. Therefore, the IBVSOs believe VA should coordinate with DoD to better address mild TBI and concussive injuries and develop a standardized protocol utilizing appropriately formed clinical assessment techniques to recognize neurological and behavioral consequences of TBI, as recommended by the Armed Forces Epidemiological Board.

Also, the influx of OEF/OIF servicemembers returning with brain injury and trauma has increased opportunities for research into the evaluation and treatment of such injuries in newer veterans; however, we suggest that any studies undertaken by VA and DoD include older veterans of past military conflicts who may have suffered similar injuries that thus far have gone undetected, undiagnosed, and untreated. Their experiences could be of enormous value to researchers interested in the progression of these injuries on a long term basis. Likewise, such knowledge of historic experience could help both DoD and VA better understand what is needed to improve screening, diagnosis and treatment of mild TBI in the newest generation of combat veterans.

Polytrauma Centers and Access to Care

For well over a decade the VA has used multiple approaches to provide specialty care to veterans and active duty members having sustained a traumatic brain injury. Established in

February 1992, the Defense and Veterans Head Injury Program (DVHIP) was restructured in 2002 as the Defense and Veterans Brain Injury Center (DVBIC). This program helps to ensure that all military servicemembers and veterans with traumatic brain injury receive TBI-specific evaluation, treatment, and follow-up through ten sites, which includes VA's TBI lead centers.

Currently VA has four designated TBI facilities collocated with its polytrauma centers: in Minneapolis, Minnesota; Palo Alto, California; Richmond, Virginia; and Tampa, Florida. These TBI lead centers provide a full spectrum of TBI care for patients suffering from moderate to severe brain injuries. VA has established 18 "polytrauma network sites" and is also establishing polytrauma support clinic teams in each of its Veterans Integrated Service Networks (VISNs) for follow-up care of polytrauma and TBI patients referred from the four lead centers or directly from military treatment facilities.

We are encouraged by VA's response to the growing demand of TBI care with the increasing number of TBI initiatives; however, resources required to operate an effective VA polytrauma network are subject to the needs of other programs and services at the local level. Accordingly, we remain concerned about system capacity in terms of space, resources and particularly staffing, and whether VA has fully addressed these factors to provide intensive rehabilitation services, treat the long-term emotional and behavioral problems that are often associated with TBI, and to support families and caregivers of these seriously brain injured veterans. It is imperative that in addition to its intensive inpatient brain injury rehabilitation program, VA must ensure proper establishment of an equally rigorous and complementary outpatient brain injury program.

To facilitate access to services, VA assigns a case manager to each OEF/OIF veteran seeking treatment at one of its medical facilities. The case manager is responsible for coordinating all VA services and benefits. Additionally, VA has hired liaison/social workers at DoD facilities to assist injured servicemembers. In interviewing case managers, the OIG found several problems that warrant attention. Case managers reported continued problems related to transfer of medical records from referring military facilities; difficulty in securing long-term placements of TBI patients with extreme behavioral problems; difficulty in obtaining appropriate services for veterans living in geographically remote areas; limited ability to follow patients after discharge to remote areas; poor access to transportation and other resources; and inconsistency in long-term case management. The report found that while many of the patients assessed had achieved a substantial degree of recovery, *"…approximately half remained considerably impaired."* The report concluded that improved coordination of care is necessary between agencies, and that families need additional support in the care of TBI patients.

The IBVSOs are concerned about increasing number of media accounts and reports from veteran patients with TBI and their family members who claim that access to VA care for TBI is not up to par or non-existent—requiring them to seek rehabilitation services in the private sector. We encourage VA and Congress to address these types of complaints to ensure severely wounded TBI veterans are receiving the best rehabilitative care available. Numerous studies show that any delay in providing comprehensive rehabilitation is a distinct predictor of long-term outcomes for veterans suffering from TBI. The need for early rehabilitative

intervention is well justified and can avoid further deterioration of these veterans in future years.

The DoD and VA share a unique obligation to meet the healthcare and rehabilitative needs of veterans who are suffering from readjustment difficulties as a result of combat service, and those who have been wounded as a result of a TBI. Therefore, the DoD, VA, and Congress must remain vigilant to ensure that federal programs are sufficiently funded and *adapted* to meet the unique needs of the newest generation of combat service personnel and veterans, while continuing to address the needs of older veterans. We hope the Secretary's recent announcement of a new VA focus on TBI will lead VA in a more coordinated direction with respect to these particular challenges. Further, in *The Independent Budget* for Fiscal Year 2008, our organizations have made a number of specific recommendations to Congress and VA based on the issues discussed today in my testimony. We invite you to consider them as you develop your legislative and oversight plans for the 110th Congress.

Mr. Chairman, this concludes my statement. I will be happy to address any questions this committee may have.